		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035469

Facility Name: Walter Lawson Children's Home

Address: 1820 Walter Lawson Drive (Number) Loves Park (City) 61111 (Zip Code)

County: Winnebago

Telephone Number: (815) 633-6636 **Fax #** (815) 633-6387

IDPA ID Number: 31-1262572

Date of Initial License for Current Owners: 08/15/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: James R. Johnson **Telephone Number:** (859) 255-0075

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) James R. Johnson
(Title) V.P. of Finance - Jefferson Medical Rehab. Centers, Inc.

Paid Preparer

(Signed) See Compilation Report (Date)
(Print Name and Title) Robert A. Thomas
(Firm Name & Address) Katz, Sapper & Miller, LLP, 11711 N. Meridian Street, Suite 800, Carmel, IN 46032
(Telephone) (317) 580-8301 Fax # (317) 580-8310

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	93	Skilled Pediatric (SNF/PED)	93	34,038	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	34,038	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	30,340	1,098	64	31,502	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,340	1,098	64	31,502	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.55%

D. How many bed-hold days during this year were paid by Public Aid?
458 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/15/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified N/A and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	167,591	27,825	8,756	204,172	386	204,558	(87,788)	116,770			1
2	Food Purchase		165,925		165,925		165,925		165,925			2
3	Housekeeping	141,804	14,279	817	156,900		156,900		156,900			3
4	Laundry	80,031	20,931	294	101,256		101,256		101,256			4
5	Heat and Other Utilities			56,299	56,299		56,299		56,299			5
6	Maintenance	47,539	4,294	22,005	73,838	404	74,242		74,242			6
7	Other (specify):*											7
8	**TOTAL General Services**	436,965	233,254	88,171	758,390	790	759,180	(87,788)	671,392			8
	B. Health Care and Programs											
9	Medical Director			12,250	12,250		12,250		12,250			9
10	Nursing and Medical Records	1,790,818	78,549	35,140	1,904,507	(704)	1,903,803		1,903,803			10
10a	Therapy	15,572		63,983	79,555		79,555		79,555			10a
11	Activities	26,012	30		26,042		26,042		26,042			11
12	Social Services			1,828	1,828		1,828		1,828			12
13	Nurse Aide Training					850	850		850			13
14	Program Transportation		1,313	2,866	4,179	(438)	3,741		3,741			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,832,402	79,892	116,067	2,028,361	(292)	2,028,069		2,028,069			16
	C. General Administration											
17	Administrative	80,952		76,951	157,903	(76,007)	81,896	(809)	81,087			17
18	Directors Fees					6,914	6,914		6,914			18
19	Professional Services			334,093	334,093	22,404	356,497		356,497			19
20	Dues, Fees, Subscriptions & Promotions			6,593	6,593	150	6,743	(825)	5,918			20
21	Clerical & General Office Expenses	60,960	17,302	20,026	98,288	25,278	123,566	(246)	123,320			21
22	Employee Benefits & Payroll Taxes			511,068	511,068	4,280	515,348	(883)	514,465			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,200	12,200	1,896	14,096	(183)	13,913			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			17,377	17,377		17,377		17,377			26
27	Other (specify):* **Bad Debts**			1,100	1,100		1,100	(1,100)				27
28	**TOTAL General Administration**	141,912	17,302	979,408	1,138,622	(15,085)	1,123,537	(4,046)	1,119,491			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,411,279	330,448	1,183,646	3,925,373	(14,587)	3,910,786	(91,834)	3,818,952			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Walter Lawson Children's Home #0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			133,342	133,342	90	133,432		133,432			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			409,209	409,209	14,632	423,841	147,761	571,602			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,751	12,751	(135)	12,616	(1,319)	11,297			35
36	Other (specify):* **Amortization**			23,846	23,846		23,846	211,315	235,161			36
37	**TOTAL Ownership**			579,148	579,148	14,587	593,735	357,757	951,492			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			265,992	265,992		265,992		265,992			42
43	Other (specify):* **Educ/Day Training**	685,634	11,640	43,117	740,391		740,391		740,391			43
44	**TOTAL Special Cost Centers**	685,634	11,640	309,109	1,006,383		1,006,383		1,006,383			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,096,913	342,088	2,071,903	5,510,904		5,510,904	265,923	5,776,827			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(35,463)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,319)	35		16
17	Non-Care Related Fees	(883)	22		17
18	Fines and Penalties				18
19	Entertainment	(183)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,100)	27		24
25	Fund Raising, Advertising and Promotional	(825)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(246)	21		28
29	Other-Attach Schedule See Attached	306,751			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 266,732		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(809)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (809)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 265,923		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Walter Lawson Children's Home

ID# 0035469

Report Period Beginning: 07/01/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	School Lunch Reimbursement	$ (87,788)	1	1
2	Amortization	(13,684)	36	2
3	Loss on Early Extinguishment of Debt	183,224	32	3
4	Loss on Early Extinguishment of Debt	224,999	36	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	306,751		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(87,788)	0	0	0	0	0	0	0	0	0	0	(87,788)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(87,788)	0	0	0	0	0	0	0	0	0	0	(87,788)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(809)	0	0	0	0	0	0	0	0	0	(809)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(825)	0	0	0	0	0	0	0	0	0	0	(825)	20
21	Clerical & General Office Expenses	(246)	0	0	0	0	0	0	0	0	0	0	(246)	21
22	Employee Benefits & Payroll Taxes	(883)	0	0	0	0	0	0	0	0	0	0	(883)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(183)	0	0	0	0	0	0	0	0	0	0	(183)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,100)	0	0	0	0	0	0	0	0	0	0	(1,100)	27
28	**TOTAL General Administration**	(3,237)	(809)	0	0	0	0	0	0	0	0	0	(4,046)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(91,025)	(809)	0	0	0	0	0	0	0	0	0	(91,834)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Walter Lawson Children's Home** **# 0035469** **Report Period Beginning:** **07/01/99** **Ending:** **06/30/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	147,761	0	0	0	0	0	0	0	0	0	0	147,761	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(1,319)	0	0	0	0	0	0	0	0	0	0	(1,319)	35
36	Other (specify):*	211,315	0	0	0	0	0	0	0	0	0	0	211,315	36
37	**TOTAL Ownership**	357,757	0	0	0	0	0	0	0	0	0	0	357,757	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	266,732	(809)	0	0	0	0	0	0	0	0	0	265,923	45

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Swann Special Care Center	Champaign			
		Exceptional Care & Training	Sterling			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland-Bean Blossom	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Health Care Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Corporate Expenses	$ 76,951	Hoosier Care, Inc.	100.00%	$ 76,142	$ (809)	1
2	V								2
3	V				Note: See schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 76,951			$ 76,142	$ * (809)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	9,654			Director Fees	$ 1,715	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	9,654			Director Fees	1,715	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	9,654			Director Fees	1,715	18.8	3
4	John Foos	Director	Board Meetings	0.00	4,984			Director Fees	885	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	4,983			Director Fees	884	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 6,914		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Hoosier Care, Inc.
Street Address: 535 West Second, Suite 105
City / State / Zip Code: Lexington, Kentucky 40508
Phone Number: (859) 255-0075
Fax Number: (859) 281-5150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Director's Fees	Revenue	36,997,938	8	$ 45,843	$ 0	5,580,243	$ 6,914	1
2	19	Professional Services	Revenue	36,997,938	8	148,540	0	5,580,243	22,404	2
3	20	Fees, Subscription & Promotion	Revenue	36,997,938	8	997	0	5,580,243	150	3
4	21	Clerical & General Office Exp.	Revenue	36,997,938	8	167,599	0	5,580,243	25,278	4
5	22	Emp. Benefits & Payroll Tax	Revenue	36,997,938	8	28,380	0	5,580,243	4,280	5
6	24	Travel & Seminar	Revenue	36,997,938	8	15,875	0	5,580,243	2,394	6
7	30	Depreciation	Revenue	36,997,938	8	597	0	5,580,243	90	7
8	32	Interest Expense	Revenue	36,997,938	8	97,010	0	5,580,243	14,632	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 504,841	$		$ 76,142	25

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Loves Park Bonds-1989A		X	Purchase of Facility	Varies	08/01/89	$ 7,305,000	$	08/01/19	9.7500	$	1
2	City of Loves Park Bonds-1999A		X	Purchase of Facility	Varies	07/08/99	5,500,000	5,465,000	06/01/34	7.1250	383,513	2
3	City of Loves Park Bonds-1999B		X	Purchase of Facility	Varies	07/08/99	250,000	245,000	06/01/19	10.5000	25,696	3
4												4
5												5
	Working Capital											
6	Home Office Allocation										14,632	6
7												7
8												8
9	TOTAL Facility Related						$ 13,055,000	$ 5,710,000			$ 423,841	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 13,055,000	$ 5,710,000			$ 423,841	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	11,734	8
	1996		9
	1997		10
	1998		11
	1999		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Note: The facility became tax exempt from property taxes starting on 01/01/96.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,182 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF/PED Facility	217,364	1989	$ 665,000	1
2			1997	19,428	2
3	TOTALS	217,364		$ 684,428	3

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1989	1971	$ 2,917,000	$ 66,591	10-40	$ 66,591	$	$ 1,072,389	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roofing			1989	1,625		5			1,625	9
10	Carpeting			1990	936		3			936	10
11	Heater / A-C			1990	17,400		5			17,400	11
12	Improvements			1991	1,563	156	10	156		1,470	12
13	Water Heater			1991	961	96	10	96		905	13
14	Door Frame Molding			1991	527	53	10	53		463	14
15	Doors			1991	738	74	10	74		634	15
16	Water Heater			1992	1,749	175	10	175		1,444	16
17	Handrails			1992	584	58	10	58		480	17
18	Roofing			1992	2,258	226	10	226		1,864	18
19	Water Line			1992	755	76	10	76		606	19
20	Smoke Dampers			1993	2,400	240	10	240		1,700	20
21	Blacktop Driveway			1993	10,130	1,013	10	1,013		6,753	21
22	Install Duct Runs			1994	750	75	10	75		488	22
23	Remodel Laundry Room			1994	3,154	315	10	315		2,022	23
24	Weather-Stripping Replacement			1994	1,849	185	10	185		1,187	24
25	Remodel Laundry Room			1994	2,063	206	10	206		1,305	25
26	A/C Roof Top Unit			1994	8,985	899	10	899		5,394	26
27	Install Sump Pump and Man Hole			1994	3,200	320	10	320		1,840	27
28	Anti-Scald Valve			1995	696	70	10	70		373	28
29	Alarm Ansul System			1995	1,253	125	10	125		667	29
30	Garbage Disposal			1995	1,067	107	10	107		544	30
31	Water Booster System Replacement			1995	6,941	694	10	694		3,817	31
32	Carpet for Offices			1995	2,432	243	10	243		1,296	32
33	Strip/Seal North Parking Lot			1995	3,382	338	10	338		1,634	33
34	Additional Parking Spaces			1995	2,375	237	10	237		1,126	34
35	Replace Gutters & Down Spouts			1995	2,150	215	10	215		1,057	35
36	TOTAL (lines 4 thru 35)				$ 2,998,923	$ 72,787		$ 72,787	$	$ 1,131,419	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install New Windows			1995	2,588	258	10	258		1,183	9
10	Gazebo Building			1995	1,676	168	10	168		770	10
11	Tile Kitchen Floor			1996	5,187	519	10	519		2,335	11
12	Bi-Fold Mirror Doors			1996	699	70	10	70		309	12
13	Clear Theralite Window Panel			1996	730	73	10	73		322	13
14	Remodel Kitchen - Ceiling Tiles			1996	279	28	10	28		121	14
15	Install Water Heater			1996	4,981	498	10	498		2,158	15
16	Install Hatco Water Heater			1996	1,550	155	10	155		672	16
17	New Roof on West Entrance			1996	1,150	115	10	115		489	17
18	Install New Mixing Valve			1996	2,960	296	10	296		1,258	18
19	Service Sink			1996	644	64	10	64		251	19
20	Vinyl Replacement Windows			1996	1,725	173	10	173		648	20
21	Install Water Heater			1997	6,014	601	10	601		2,054	21
22	Shower Trolley			1997	10,924	1,092	10	1,092		3,640	22
23	Stonebridge Tile-Bathing Area			1997	666	67	10	67		223	23
24	Drain, Lines, Vent Shower Trolley			1997	1,340	134	10	134		447	24
25	Install 175 Watt Fixture			1997	1,427	143	10	143		477	25
26	Replace Temperature Control Board - A/C			1997	1,021	102	10	102		332	26
27	Water Circulation Pump			1997	675	68	10	68		210	27
28	Re-Roof North Wing, Gravel Roof			1997	27,597	2,760	10	2,760		8,509	28
29	Parking Lot			1997	9,898	990	10	990		2,805	29
30	Fence			1997	5,680	568	10	568		1,562	30
31	Dirt & Sod			1997	1,075	108	10	108		288	31
32	Reinstall AC Roof Top Unit			1997	2,975	297	10	297		891	32
33	Security System			1997	2,362	236	10	236		688	33
34	Hopper Service Sink			1997	660	66	10	66		187	34
35	Install Frame/Door			1997	1,135	57	20	57		152	35
36	TOTAL (lines 4 thru 35)				$ 97,618	$ 9,706		$ 9,706	$	$ 32,981	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Education Wing			1997	137,582	6,879	20	6,879		18,344	9
10	Contractor's Fee - Education Wing			1997	73,788	3,689	20	3,689		9,838	10
11	V.C. Tile			1997	610	31	20	31		82	11
12	Contractor's Fee - Education Wing			1997	40,125	2,006	20	2,006		5,350	12
13	Install Fire Alarm Panel			1997	700	35	20	35		93	13
14	Ductwork On Roof			1997	538	27	20	27		72	14
15	Re-locate Roof Top Unit			1998	4,712	236	20	236		629	15
16	Grade & Sod			1998	520	52	10	52		139	16
17	Contractor's Fee - Education Wing			1998	26,724	1,336	20	1,336		3,563	17
18	Replace Blower Motor			1998	620	62	10	62		160	18
19	Pour New Concrete			1998	945	95	10	95		237	19
20	Install Emergency Generator			1998	85,328	8,533	10	8,533		21,332	20
21	Cabinets & Countertops			1998	788	79	10	79		197	21
22	Replace Inducer Motor			1998	837	84	10	84		203	22
23	Replace Heat Exchanger, Burners & Deflection Plate			1998	1,228	123	10	123		287	23
24	Install New Receptacle, Box & Separated Circuits			1998	1,639	164	10	164		383	24
25	Roof			1998	700	70	10	70		157	25
26	Install Thermaltite Window			1998	570	57	10	57		124	26
27	Blacktop New Parking Lot and Driveway			1998	9,752	975	10	975		1,950	27
28	Install New Aluminum Siding/Install New Gutter			1998	1,397	140	10	140		280	28
29	Replace Gas Valve, Thermostats, Circuit Board, Ignitor			1998	1,008	101	10	101		177	29
30	Install New Roof-Top Heating / Air Conditioning Unit			1999	4,340	434	10	434		651	30
31	Re-Tile Bathtub Room Floor and Walls			1999	2,080	208	10	208		312	31
32	New Bathtub, Install Drain, Vent, Water Lines			1999	1,780	178	10	178		252	32
33	Install New Sink			1999	676	68	10	68		107	33
34	Heat Exchanger			1999	912	91	10	91		121	34
35	Roof-Top Unit Replace Motor			1999	731	73	10	73		84	35
36	TOTAL (lines 4 thru 35)				$ 400,630	$ 25,826		$ 25,826	$	$ 65,124	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Tear Off and Replace Roof			1999	2,500	125	20	125		125	9
10	Install New Roof Shingles, Facia Boards & Vents			1999	3,727	124	20	124		124	10
11	Furnish and Install True 2-Door Freezer			1999	3,265	145	15	145		145	11
12	Install New Heat Exchanger			2000	730	24	15	24		24	12
13	Extension and Enlargement of Sewer System Pipes			2000	1,804	60	15	60		60	13
14	Installed New 50 Gallon Water Heater			2000	918	20	15	20		20	14
15	New Toshiba Strata Digital Telephone System			2000	3,264	109	10	109		109	15
16	New Toshiba Strata Digital Telephone System			2000	6,528	218	10	218		218	16
17	New Toshiba Strata Digital Telephone System			2000	1,478	49	10	49		49	17
18	Tear Off and Replace North Flat Roof			2000	1,147	10	20	10		10	18
19	Rounding					(1)		(1)			19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 25,361	$ 883		$ 883	$	$ 884	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 88,850	$ 13,892	$ 13,892	$		$ 58,789	37
38	Current Year Purchases	10,912	1,102	1,102			1,102	38
39	Fully Depreciated Assets	437,903	4,264	4,264			437,903	39
40	Home Office Allocation		90	90				40
41	TOTALS	$ 537,665	$ 19,348	$ 19,348	$		$ 497,794	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Staff & Patient Transport	1997 Ford Club Wagon	1990	$ 3,120	$	$	$	3	$ 3,120	42
43	Staff & Patient Transport	A/C for Ford Club Wagon	1998	1,040	347	347		3	1,040	43
44	Staff & Patient Transport	1999 Dodge Van	1999	22,678	4,535	4,535		5	6,803	44
45										45
46	TOTALS			$ 26,838	$ 4,882	$ 4,882	$		$ 10,963	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,771,463	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 133,432	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 133,432	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,739,165	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 5,423 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Transportation	1997 Mercury Sable	$ 586.14	$ 920	17
18	Transportation	1999 Mercury Sable	589.00	6,273	18
19					19
20					20
21	TOTAL		$ 1,175.14	$ 7,193	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$ 850	$ 850
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$ 850	$ 850
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Walter Lawson Children's Home # 0035469 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 800	$	1
2	Cash-Patient Deposits	52,705		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,200)	855,261		3
4	Supply Inventory (priced at Cost)	18,280		4
5	Short-Term Investments			5
6	Prepaid Insurance	(14,164)		6
7	Other Prepaid Expenses	1,768		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Corporate	214,548		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,129,198	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	684,428		13
14	Buildings, at Historical Cost	3,522,533		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	564,502		16
17	Accumulated Depreciation (book methods)	(1,739,165)		17
18	Deferred Charges	345,526		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,868		21
22	Other Long-Term Assets (specify):	585,416		22
23	Other(specify): Goodwill	397,968		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,364,076	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,493,274	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 43,334	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	52,705		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	127,505		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,204		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	34,592		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 261,340	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,710,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,710,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,971,340	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (478,066)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,493,274	$	48

***(See instructions.)**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (174,645)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (174,645)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(303,421)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (303,421)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (478,066)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,671,788	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,671,788	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	476,728	9
10	Other Government Grants	9,561	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 486,289	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	35,463	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 35,463	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DMH Day Training	334,378	28
28a	See Attached	(320,435)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,943	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,207,483	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	758,390	31
32	Health Care	2,028,361	32
33	General Administration	1,138,622	33
	B. Capital Expense		
34	Ownership	579,148	34
	C. Ancillary Expense		
35	Special Cost Centers	740,391	35
36	Provider Participation Fee	265,992	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,510,904	40
41	**Income before Income Taxes (line 30 minus line 40)****	(303,421)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (303,421)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,898	2,091	$ 58,542	$ 28.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,373	14,932	306,164	20.50	3
4	Licensed Practical Nurses	21,946	24,499	422,029	17.23	4
5	Nurse Aides & Orderlies	95,445	101,681	1,004,083	9.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	947	947	15,572	16.44	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,107	4,402	26,012	5.91	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,020	2,294	33,136	14.44	13
14	Head Cook	7,685	8,481	94,960	11.20	14
15	Cook Helpers/Assistants	3,496	3,805	31,358	8.24	15
16	Dishwashers	1,309	1,367	8,137	5.95	16
17	Maintenance Workers	1,945	2,199	47,539	21.62	17
18	Housekeepers	12,824	14,170	141,804	10.01	18
19	Laundry	9,133	9,979	80,031	8.02	19
20	Administrator	2,000	2,080	80,952	38.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,341	3,776	60,960	16.14	24
25	Vocational Instruction					25
26	Academic Instruction	34,673	38,716	485,994	12.55	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,521	8,139	112,216	13.79	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	7,002	7,952	87,424	10.99	33
34	TOTAL (lines 1 - 33)	230,665	251,510	$ 3,096,913 *	$ 12.31	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	210	$ 7,920	1.3	35
36	Medical Director	392	12,250	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	608	36,475	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	423	27,405	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental Fees	N/A	9,599	10.3	46
47	Education	249	7,124	43.3	47
48	Housekeeping	82	800	3.3	48
49	TOTAL (lines 35 - 48)	1,964	$ 101,573		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,059	23,197	10.3	52
53	TOTAL (lines 50 - 52)	1,059	$ 23,197		53

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theo Brandel	Administrator	0	$ 80,952
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,952

B. Administrative - Other

Description	Amount
Corporate Expenses	$ 76,951
TOTAL (agree to Schedule V, line 17, col. 3)	$ 76,951
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Jefferson Medical Rehabilitation		$
Centers, Inc.	Management	331,200
Katz, Sapper & Miller, LLP	Accounting Fees	2,778
Holleb & Coff	Legal Fees	115
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 334,093

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,210
Unemployment Compensation Insurance	15,743
FICA Taxes	225,211
Employee Health Insurance	178,821
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	12,200
Corporate Allocation	4,280
TOTAL (agree to Schedule V, line 22, col.8)	$ 514,465

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	914
(Indicate # of checks performed 75)	
Illinois Health Care Assoc.	3,520
Public Relations	650
Miscellaneous Dues & Subscriptions	1,334
Corporate Allocation	150
Less: Public Relations Expense	(650)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,918

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	10,452
Non-Allowable Travel	(183)
Seminar Expense	1,250
Corporate Allocation	2,394
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,913

**See instructions.

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 07/01/99 Ending: 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Schedule XIX, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,848** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **265,992**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **87,788**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes (Owned) / No (Leased)**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **PriceWaterhouseCoopers** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.